299

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Good morning, Sen. Crisco, Rep. Fontana and members of the Insurance and Real Estate Committee. My name is Dina Berlyn. Some of you might recognize me at the LOB as State Senate Majority Leader Martin Looney's Counsel and Executive Aide, which I am, but I am not here in that role. I am a patient with multiple sclerosis. I am here to testify on a healthcare policy issue of deep personal interest to me: coverage of routine patient care costs in clinical trials. S. B. No. 299 AN ACT EXPANDING HEALTH INSURANCE COVERAGE FOR ROUTINE PATIENT CARE COSTS FOR CLINICAL TRIAL PATIENTS would make our healthcare coverage more compassionate and more sensible.

I have researched, written, and been published on coverage of routine patient care in clinical trials, and I want to share with you my discoveries about this matter -- particularly the irrational nature of the for-cancer-only provision in our statutes.

In 2001, the Connecticut General Assembly passed PA 01-171 AN ACT CONCERNING HEALTH INSURANCE COVERAGE FOR CANCER CLINICAL TRIALS, HEARING AIDS FOR CHILDREN AGE TWELVE AND YOUNGER, PAP SMEAR TESTS, COLORECTAL CANCER SCREENING AND MAMMOGRAMS, PSYCHOTROPIC DRUG AVAILABILITY AND MEDICAID COVERAGE FOR MAMMOGRAMS[1]. The bill started with a more conventional title: AN ACT CONCERNING HEALTH INSURANCE COVERAGE DURING CLINICAL TRIALS. This legislation had laudable goals – to require insurers to sustain their responsibility to patients who participate in clinical trials by covering standard of care treatment for clinical trial patients. Unfortunately, this bill in its final form required coverage for cancer clinical trials only. Many insurers already covered these expenses for cancer due to the high visibility and influence of cancer care and the use of NIH cooperative groups. While this

[1] In 2007 PA 07-67 made some changes regarding required coverage for out of network costs in cancer clinical trials